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FOREIGN BROADCAST INFORMATION SERVICE

JPRS Report

Epidemiology

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JPRS-TEP-90-006 *29 May 1990*

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Recent material on AIDS will be published in a later issue.

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CAMEROON

Plans for Anti-Cricket Campaign

54000044A Yaounde CAMEROON TRIBUNE in French 11-12 Mar 90 p 5

[Article by Ndongo Ondua: "The 1990 Campaign Is Being Readied"; first paragraph is CAMEROON TRIBUNE introduction]

[Text] The alarm was sounded last Thursday in the National Anti-Cricket Committee. For the year just under way, a onslaught of grasshoppers is expected.

The National Anti-Cricket Committee met Thursday in the ceremonies room of the Ministry of Agriculture. The meeting was held in an atmosphere of looming crisis. An onslaught of crickets and grasshoppers is expected for the coming rainy season. Necessary arrangements must therefore be made, human needs assessed, and equipment obtained to effectively deal with the situation.

The minister of agriculture, joined by the state secretary of the same ministry, made an urgent appeal for the event. Relevant organizations such as the Airborne Agricultural Spraying Unit (UTAVA) and specialized divisions such as the plant-health bases and brigades must mobilize for the event. The strategic period for effective spraying is only two months away.

It is easier to understand the urgency of the problem when you see the huge amount of equipment that must be acquired in such a short time. In his speech presenting the plan of action and needs for 1990, Mr. Ndombou Jean, assistant director of flora protection, enumerated the infrastructure, equipment, and specialized personnel needed. The radio system will have to be improved, landing strips readied, and adequate supplies of pesticide obtained. It is also necessary to buy motorcycles and vehicles, acquire camping equipment, and plan for the fuel for both cars and crop-duster planes.

In addition, all this equipment will require men capable of operating and maintaining it. Considering the shortages in that area, training courses and retraining seminars will have to be organized. Moreover, there is only one pilot for every three needed. All this must be available in two months. It is therefore easy to understand why the minister of agriculture has turned to international organizations and friendly countries, which often take part in the anticricket battle at Cameroon's side. Organizations such as the FAO (Western Armed Forces), the UNDP [UN Development Fund, the EEC, USAID [US Agency for International Development], the World Bank, and ASECNA (Agency for Air Navigation and Safety in Africa and Madagascar) were invited to Thursday's meeting. Also present were the French Aid and Cooperation Mission and representatives of certain friendly countries: Partners who always know how to round out our efforts in the constant battle against these real agricultural scourges. To understand the general mobilization in the fight against crickets, it should be pointed out that for three years the north of our country, the eastern province, and even certain sections of the center and south have been invaded either by foliage-devouring caterpillers or various grasshoppers or migratory crickets. The upcoming campaign will involve coverage of 150,000 hectares, either through ground applications or crop dusting from the air. It is an enormous challenge that will have to be met. Already on Friday, a large shipment of equipment was handed over to the Ministry of Agriculture, through the generosity of the Western Armed Forces. It consisted of sprayers and body-protective equipment. The whole lot is worth 70 million CFA [African Financial Community] francs and will be shipped to Garoua, to shore up our anticricket capabilities.

MADAGASCAR

Nomad Cricket Invasion Being Monitored

90WE0178A Antananarivo MIDI MADAGASIKARA in French 3 Mar 90 p 4

[Text] A controversy? No—more of an update. For though the south of Madagascar has indeed been invaded by crickets, they could not have destroyed "over 2,000 tons of corn and several thousand tons of manioc" in the region of Ampanihy, as reported by the Taratra national agency (ANTA).

During a press conference yesterday afternoon, the Plant Protection Division pointed out two things: First, after a cricket swarm has passed through, the ears of corn are often, if not generally spared, at least only damaged in the leaves. Second, manioc roots are not easily reached by the crickets.

While not meaning to deny the information reported by ANTA, the agency primarily wanted to reassure public opinion, despite the real existence of a cricket invasion in the south. It is a seasonal invasion which, this year, was marked by a three-fold increase in the number of so-called migratory crickets, the most devastating sort. But the situation is not as serious as in previous years.

Two years ago, the invasion forced crop-dusting of 150,000 hectares, compared to 120,000 last year. During the 1981-82 crop year, 800,000 hectares were sprayed by plane.

Crop-dusting is only necessary when the situation is serious. In other words, the situation is not critical enough so far to have prompted spraying yet. This is because of the work done since the start of the crop year with the help of the FRG, which assists in the anticricket project, and of the decentralized collectives whose reports of any cricket hatchings are decisive. But, proving that every cloud has a silver lining, the low rainfall is also responsible for preventing the invasion from assuming drastic proportions.

According to officials, rain does promote hatching of cricket eggs. The high migratory-cricket growth rates

compared to previous years were therefore explained by the December and January rains. Since then, the rains have ceased. Furthermore, since this type of cricket only reproduces once a season (from December to April), there is nothing more to fear.

This does not keep officials from monitoring the situation daily, if not hourly. For we are not entirely home free (heavy rains could cause the hatching of a new generation of crickets), though a possible invasion could no longer cause much damage since the agricultural season is drawing to an end with the harvest.

Nonetheless, to achieve total control of the situation, officials hope to step up collaboration with peasant farmers and decentralized collectives. It was by working with them, and through their reporting of hatching zones, that the public disaster of a cricket invasion was able to be curbed. So far, 422 hectares of land have been sprayed in the Ampanihy "fivondronana." Thanks again to reporting by decentralized collectives, 1,019 hectares were sprayed in the country's cricket-breeding zone. The area, located in the south and covering a total of 60,000 square km, is monitored constantly by anticricket teams. And for good reason: The damage caused can be enormous. But spraying is also costly: A liter of the product used costs 18,000 Madagascar francs, and it takes half a liter per hectare for airborne applications and 1.5 to 2 liters/hectare for ground spraying.

In the fight against crickets as elsewhere, an ounce of prevention is worth a pound of cure.

MAURITIUS

High Rate of Diabetes Raises Concern

90WE0145A Port Louis LE MAURICIEN in French 7 Mar 90 pp 1,4

[Article by Dharmanand Dhooharika: "One Out of Two Mauritians, Aged 45 and Over, Suffers From Diabetes"; first paragraph is LE MAURICIEN introduction; passages within slantlines published in English]

[Text] This morning, on the occasion of the official opening of the International Symposium on Diabetes held at the University of Mauritius in the Octave Wiehe Hall, Jagdish Goburdhun, the minister of Mauritian health, declared that one out of two Mauritians aged 45 and over, or 45 percent of the Mauritian population, suffers from diabetes and runs the risk of developing more serious diabetic problems.

Ten experts—namely, the doctors Paul Zimmet, Harris R. de Fronzo, G. Reaven, J. Tuomilehto, O. Faber, H. Leboritz, and L. Gruup—and members of two international medical organizations, /(International Group for the study of type II Diabetes and the International Diabetes Federation)/—the professors George Alberti, A. Melander, and H. Gareeboo among them—are participating in this international symposium, which is under the patronage of the A.E. Patel Pharmacy, the representative of the "Carloerba" Laboratory.

The minister of health stated that he was concerned with the high prevalence of diabetes in Mauritius. Minister Goburdhun pointed out that the death rate due to diabetic complications was higher here than in other industrialized countries.

Jagdish Goburdhun further added: "Mauritius has now become an industrialized country and it is our duty to protect our human resources. One of the reasons for the government's particular interest is its intention to establish a diabetes prevention program."

According to a medical survey recently conducted by diabetes specialists from various international medical institutions, 12.8 percent of the adult Mauritian population is already suffering from diabetes and 18 percent already has abnormal blood sugar levels.

Moreover, remarked Minister Goburdhun, 15 percent of the Mauritian population suffers from hypertension and 50 percent has a high cholesterol level.

Jagdish Goburdhun acknowledged this morning that cardiovascular diseases continue to be a serious danger to public health, despite the implementation of national prevention committees.

Jagdish Godburdhun declared: "Cardiovascular diseases weigh heavily on the budget of the Ministry of Health. We have already set up a program of intervention at a national and regional level for the purpose of controling these complications."

Prevention measures and early hypertension and diabetes detecting programs, if not self-detecting, are proving necessary.

Jagdish Goburdhun—who was surrounded by several participants, including his permanent secretary Ranjir Goordyal and Sir Djamil Fareed, the WHO [World Health Organization] representative, and diabetes specialists—spoke about the need to launch a vast campaign for the purpose of raising the population's awareness about these diseases.

Jagdish Goburdhun pointed out that his ministry is already working very hard against tobacco addiction, alcoholism, obesity, and bad nutritional habits. It should be recalled that, in consideration of the professed desire to continue working toward the goal of health for all, the various participants will submit reports on supervisory programs.

NIGERIA

Cerebro Spinal Meningitis Kills 31 in Sokoto State

54000061b Ilorin SUNDAY HERALD in English 8 Apr 90 p 1

[Text] Cerebro-spinal meningitis claimed 31 lives within the last two weeks in Keta and Danjigbu villages of Tsete Local Government Area in Sokoto State, the New Agency of Nigeria (NAN) reports.

According to NAN, 21 of the deceased persons were from Keta among whom were 11 people who were said to have come from Malam Sheu village.

Also among the victims was a 13 year old girl named Amina who was said to have fixed her marriage for next month.

TANZANIA

Cholera Outbreak Kills 5 Persons in Lindi District

54000061c Dar es Salaam DAILY NEWS in English 4 Apr 90 p 1

[Text] Five people have died and 19 others admitted at Nyangao Mission Hospital, Mtama Division, Lindi Rural District, following an outbreak of cholera last month.

Lindi Regional Medical Officer Sali Kajala said two of the victims died at Nyangao Village while the rest died at the hospital, SHIHATA reported.

He said 38 people contracted the disease since its outbreak at the village on 22 March, this year.

ZAMBIA

670 Cholera Cases in Lusaka

82 Deaths Recorded

54000030B Lusaka TIMES OF ZAMBIA in English 22 Feb 90 p 7

[Excerpt] The cholera death toll rose to 82 in Lusaka when two victims died in Chawama and University Teaching Hospital (UTH) a Ministry of Health statement said yesterday.

An earlier statement said that the total number of people who died in treatment centers stood at 72 in Lusaka Urban, Kabwe and Mumbwa districts out of which eight were brought in dead.

Kanyama, Tunduya and George townships were the only areas said to be the worst hit.

More health workers were mobilized to fight the scourge which broke out earlier this month and ten health workers were brought in from Eastern Province to assist in the affected areas.

Chikondano which was among the first townships to report the outbreak has so far recorded no deaths.

The number of cholera cases reported since the outbreak now stands at 670.

Meanwhile, Lusaka's Soweto market has finally been re-opened after two weeks of closure but sales of fresh meat and fish are still banned.

The market, which had been closed since February 12, in a bid to combat cholera re-opened after marketeers together with council workers cleaned the place and renovated some stalls.

The surroundings of the market have been transformed. New drainages and sales areas have been demarcated.

When the TIMES team visited the market yesterday, the market was found "unusually clean." [passage omitted]

Death Toll Stands at 89

Lusaka TIMES OF ZAMBIA in English 26 Feb 90 p 7

[Excerpt] Two more cholera victims died yesterday morning as the scourge continues ravaging the capital city bringing the death toll to 89.

Sources at Nakatindi treatment center confirmed the death of the two Kanyama residents. Kanyama, Tunduya and George townships were still a source of concern to health authorities.

The source said the two deaths were reported early yesterday morning.

"The cases are being treated as police cases because they occurred outside a treatment center. Since police refuse handling cholera victims, we were called in."

"The problem is that in the townships patients are taken late to the treatment centers, otherwise there could have been no deaths," the source indicated.

Meanwhile, the Government is studying ways of treating the water system in the affected townships as a way of curbing the cholera epidemic in Lusaka. [passage omitted]

16 Measles Deaths in Hospital in February

54000030C Lusaka TIMES OF ZAMBIA in English 5 Mar 90 p 7

[Text] Measles isolation ward at Kasama General Hospital is overcrowded and some mothers and their sick children are sleeping on the floor.

The killer disease is still on the increase despite the vaccination campaigns in the area.

A survey yesterday found that 29 measles cases are admitted in the hospital while 16 deaths have been recorded since the beginning of February.

Medical sources within the ward said the ward is supposed to accommodate only ten patients but because of pressure, 29 patients have been admitted and among those sleeping on the floor was a mother and her sick three-month-old twins.

Two weeks ago, provincial medical officer Dr Albert Sitali, appealed to mothers in the area to respond positively to the ongoing campaign against measles to reduce deaths of children.

But sources within the measles isolation ward said most mothers brought their afflicted children to the hospital late and such cases resulted in deaths.

The sources added that on Friday, they discharged 11 cases of measles and the same day another 12 cases of the same disease were admitted and most of these were from the outlying areas of the district.

Chinsali district reported 311 cases of measles between November last year and February this year out of which 12 children died.

Reports from Luwingu indicate that 630 children have been vaccinated against the disease but no deaths have been reported while there was no record to indicate that the disease has spread to other districts.

Anthrax Outbreak Claims 9 Lives, 200 Cattle

54000030D Lusaka TIMES OF ZAMBIA in English 22 Feb 90 p 7

[Text] Deadly anthrax that claimed nine human lives and 200 cattle lives in Mumbwa has broken out in Mongu, a spokesman at the Ministry of Agriculture revealed in Lusaka yesterday.

He could not give the figure of how many people and cattle were victims of the scourge in Kama area in Mongu but the ministry had already sent vaccines.

The outbreak there was rather unusual because it has appeared at a wrong time of the year.

"Normally anthrax outbreaks occur in the dry season, towards the end of the year when grass is either scarce or just germinating. Anthrax bacteria is soil borne," he explained.

However, director of veterinary services Dr George Chizyuka left yesterday for Mongu to monitor the situation.

Anthrax was first detected last October in Senior Chief Shakumbila's area in Mumbwa and caused great concern to the area ward chairman Cde Goliath Nkatiko asked for prompt Government action.

An epidemiologist sent to investigate the outbreak in Mumbwa said all the cattle in affected areas had been vaccinated.

The spokesman appealed to all farmers to report all cases of cattle dying of suspicious diseases and for villagers to shy away from eating dried meat obtained from animals that had died mysteriously.

Health Ministry Reports on 1989 Epidemics

90WE0111C Beijing RENMIN RIBAO (OVERSEAS EDITION) in Chinese 22 Dec 89 p 4

[Article by Feng Junjun [7458 6511 6511], reporter of the People's Daily News: "Ministry of Public Health Reports on Epidemics in 1989; the Overall Epidemic Occurrence Rate Has Declined, Outbreaks of Poliomyelitis and Others Are on the Rise"]

[Text] Beijing—Dai Zhicheng [2071 1807 3397], Director of the Department of Disease Control, Ministry of Public Health, announced in Beijing today that the epidemic control situation has improved in 1989. Although there have been ups and downs in the occurrence rates of the 25 communicable diseases which must be reported by law, the general trend is downward.

Dai Zhicheng made this announcement in his report on the epidemic control situation in 1989. He said the number of reported cases of the 25 major epidemics from January to October of this year is 30 percent lower than that for the same period last year. The major reductions are hepatitis, down by 250,000 cases compared to the same period last year; influenza, down by some 500,000 cases; and dysentry, down by some 400,000 cases. Furthermore, the occurrences of cholera, measles, hemorrhagic fever, epidemic encephalitis, typhoid, paratyphoid, pertussis and encephalitis B have shown various degrees of decline; whereas nearly equal numbers of cases of leptospirosis, recurrent fever and Kala-azar were reported as last year.

Dai Zhicheng added that there are also causes for concern. While the overall epidemic occurrence rates have exhibited a downward trend, occurrences of certain communicable disease are on the rise. These diseases, including poliomyelitis, anthrax and rabies, have shown relatively large increases in incidences.

According to his report, 3,619 cases of poliomyelitis were reported between January and September this year, representating an increase of seven and a half times over the same period last year. Nationwide, higher occurrences were reported in 16 provinces. A statistical study of poliomyelitis cases from 14 provinces indicates that infants under 1 year old are particularly susceptible; this age group has accounted for 75 percent of all reported cases. Dai Zhicheng felt that this finding clearly pointed out the inadequacies in disease-control organizations at community levels and the lack of skilled public-health disease-control personnel. The data collected on poliomyelitis and the administration of immunization, which data Dai distributed in the session, showed that 84.7 percent of the 3,453 cases examined had either not been vaccinated at all or only inadequately vaccinated. This circumstance is contributing to the spread of poliomyelitis.

Dai Zhicheng said that in addition to poliomyelitis, outbreaks of anthrax and rabies are on the rise as well. The epidemic of anthrax, although reported only in some regions of Tibet and Guizhou, had an occurrence rate that showed a growth of 30 percent over that of the same period last year. An annual increase in incidence of 11 percent was observed for rabies.

Dai Zhicheng expressly called people's attention to the fact that despite the drop in the nationwide occurrence rate of hepatitis in 1989, an upward trend of this disease has been developing in regions north of the Yangtze River. For example, the hepatitis occurrence rate in Beijing this year is 20 percent higher than that of the same period last year. He believed that three causes played a major role in the jump: 1) repeated natural disasters; 2) the large population migration following the civil unrest in April, May and June this year; and 3) the reduced immunity of the general public as a result of the steadily declining epidemic occurrence rates in the past several years.

Epidemics Wane for Decade Low

54004813 Beijing CHINA DAILY in English 29 Mar 90 p 3

[Article by Zhu Baoxia]

[Text] Epidemics killed 13,844 people in China last year, a 15 percent decrease from the year before, the Ministry of Public Health has announced.

The incidence of these diseases last year was 339 cases per 100,000 people, according to a ministry release, a 27 percent decline from 1988 figures.

These figures are the lowest of the decade.

The incidence of 13 diseases including cholera, typhoid, hepatitis, dengue fever, meningitis, measles and whooping cough decreased by 11 to 18 percent.

Yet the incidence of plague, polio, rabies, diphtheria and malaria increased.

Ten plague cases were reported last year, six of them fatal.

Most of these cases were in the Tibet Autonomous Region, and in Qinghai and Gansu provinces.

The incidence of polio is 4 cases in 1 million people, 5.5 times more than in 1988. The ministry attributes this to inadequate medical services and incomplete immunization.

Eleven provinces reported more than 100 cases of polio making up 91 percent of the cases throughout the country.

These 11 were Jiangsu, Hainan, Jiangxi, Fujian, Anhui, Shaanxi, Henan, Hebei, Shandong, Gansu and Guangdong provinces.

Pixian County in Jiangsu had more than 600 polio patients.

Anthrax cases rose by 30 percent last year and killed 308 people, mainly in remote and mountainous regions of Tibet and Sichuan Province.

Diphtheria increased by 28 percent last year. Most of the patients were adults.

Last year, 5,156 people were infected with rabies and all but one perished. This accounted for 37 percent of the deaths from epidemics in 1989.

Epidemic control stations throughout the country reported 172 people were exposed to the AIDS virus in 1989.

That brings the total number of people in China exposed to the virus to 194: 153 Chinese persons and 41 foreigners.

These cases appeared in 10 provinces, autonomous regions and municipalities across the country. Of the total Chinese people affected, 146 are intravenous drug users, two were infected outside the country, one is a male homosexual and four others were exposed to the virus by blood transfusions with foreign blood.

The incidence of venereal disease is growing rapidly in the country.

VD Epidemic, Prevention Measures

90WE0111A Beijing GUANGMING RIBAO in Chinese 27 Nov 89 p 2

[Article by Yuan Zhaozhuang [5913 0340 8369], Associate Professor in the Department of Dermatology, the Union Hospital, Beijing: "Demographic Characteristics of the VD Epidemic and Our Prevention and Control Measures"]

[Text] Venereal diseases, formerly known as hua liu bing, generally cover the following four diseases: syphilis, gonorrhea, chancroids and venereal granuloma. However, in 1976, the Standing Council of the World Health Organization decided to group all sexually transmitted diseases under the term of venereal diseases (abbreviated as VD), which include, in addition to the four aforementioned diseases, more than 20 other sexually transmitted diseases such as granuloma inguinale, nongonococcal urethritis, genital herpes, pointed condyloma, genital warts, pudendal candidiasis or moniliasis, vaginal trichomoniasis, public phthiriasis, scabies and AIDS.

In recent years, the upsurge of venereal diseases in our country has been alarming. It has been reported that between 1982 and 1987, the number of VD cases grew at an annual rate of 312 percent. Judging from the general developing trend of the VD epidemic, these diseases appear to be spreading through the following pathways: foreign countries and Hongkong-Macao to Special Economic Zones, tourist attractions and open cities to and from big and medium-sized cities to and from small towns and hometowns of overseas Chinese to small villages and rural mountain areas.

Studies have shown that the current VD epidemic in our nation exhibits the following characteristics:

Young men and women are most susceptible and the trend is towards an ever younger crowd. A breakdown of 14,896 VD cases indicates that 74.03 percent of the patients are aged 20-39, 8.05 percent are 19 or younger and the youngest patient is only 13 years old.

The prevalence of male patients in VD cases is also observed. Of the 14,896 cases mentioned previously, there were 10,506 male cases, accounting for 70.5 percent, and 4,390 female cases, for 29.5 percent.

An occupational background analysis shows that the majority of VD patients are trade workers. Studies conducted on the 329 cases in the Beijing area between January and October of 1987 gave the following order of occupation distribution: trade workers; the self-employed; government, party and military cadres; the young employed; truck drivers; service- industry workers; professionals, and students, followed by peasants. The trade workers' cases totalled 94; most of them were construction workers from rural areas.

Case studies have also revealed that most of the patients had either a junior-high or senior-high-school education. Of the 14,896 VD patients investigated, 4,710 were junior-high-school graduates or 31.62 percent of the total; 3,434 senior-high-school graduates, or 23.05 percent; 1,981 with an elementary-school education, or 13.30 percent; 311 college graduates, 2.09 percent; and 201 illiterates, 1.35 percent.

There is a marked increase of homosexuals in VD patients. In 1987, over half of the 85 reported syphilis cases in an unnamed area were homosexuals. Of the 73 syphilis patients currently receiving treatment in our clinic, 17 are homosexuals.

An overall increase in premarital and extramarital sexual relations has contributed to the spread of the VD epidemic.

Our study indicates that whereas the incidence of syphilis is declining, the incidence of gonorrhea is on the rise. The number of cases of gonorrhea induced by penicillin-resistant gonorrhoeae [i.e., gonococci] is increasing steadily and an increase in incidence of viral VD has been observed as well; for example, in some areas, there are more reported cases of pointed condyloma than gonorrhea.

To prevent further dissemination and to eventually eradicate VD, our national government has implemented a series of countermeasures in recent years.

In 1985, the State Council approved and circulated a "Report on a Firm Ban on Prostitution Activities and Control of the Epidemic of Venereal Diseases," jointly

submitted by the Ministry of Public Security, the Ministry of Justice and the Ministry of Public Health. The State Council followed up this report in 1986 with a "Memorandum on a Firm Ban on Prostitution Activities and Control of the Epidemic of Venereal Diseases." The Ministry of Public Health subsequently set up a Venereal-Disease-Control Advisory Commission in July 1986 and the National Venereal-Disease Control Center in October 1987. As part of their campaign to step up the detection and tracing of contacts as well as treatment of venereal diseases, regional public-security, justice, civil-affairs and travel and tourism authorities have joined forces with the Women's Federation and Communist Youth League branches to introduce or re-establish mandatory VD tests in physical examinations for people considered to belong to the high-risk group.

Today VD education classes, teaching the general public how to combat sexually transmitted diseases, are being organized in many areas by local authorities. This program is aimed at educating people to exercise self-control so as to protect themselves from contracting VD and to promote awareness of the danger of VD.

Principal medical schools and secondary paramedic schools have updated and improved the course contents regarding VD prevention and control. This is supplemented by a training program, conducted in various parts of the country, to provide medical professionals with on-the-job training in VD prevention and treatment. In addition, detection and tracing-of-contacts stations and VD prevention and control centers are being organized on a community level as well.

The adoption of public health laws is expected to help control the spread of VD. For example, the "Territorial Health Quarantine Law and Detailed Regulations for Its Implementation," enacted on 1 May 1987, debars foreign nationals, infected with either VD or AIDS, from entrance into this country. Under the stipulations of this law, the local public health department reserves the right to petition the public security authority to expel an alien suspected of being infected with sexually transmitted diseases during his stay in China. Furthermore, the first Chinese law on the prevention and control of AIDS, "Regulations on the Detection of and Follow-up on AIDS," were implemented on 14 January 1988.

With the support of national and provincial funding, many new diagnostic methodologies and treatments for venereal diseases have been introduced from abroad or developed locally.

The nationwide resurgence of venereal diseases has caused great public concern. However, the constant danger that VD can be transmitted by human carriers from abroad, illegal prostitution, the reticence of VD patients, people's ignorance of VD and the lack of qualified medical personnel, as well as the need for diagnostic kits and medical supplies contribute to make the control and prevention of venereal diseases a formidable and lasting challenge for all of us.

PRC, Hong Kong, Macao To Control Communicable Dieases

OW2104023590 Beijing XINHUA in English 0052 GMT 21 Apr 90

[Text] Hong Kong—The Chinese mainland, Hong Kong and Macao have agreed on a series of measures for joint collaboration in the surveillance and exchange of information on the control of communicable diseases, Director of Health Dr. S.H. Lee said here yesterday.

Lee attended a meeting in Macao from April 16 to 18 on the control of communicable diseases in the region at the head of a three-man health delegation.

Officials from Macao and the Chinese Ministry of Public Health, Guangdong Province, Hainan Province and three cities of Guangzhou, Shenzhen and Zhuhai also participated in the meeting.

Among the main topics discussed at the meeting were cholera, malaria, viral hepatitis and AIDS and HIV surveillance.

The meeting noted the occurrence of cholera last year in Hong Kong, Macao, Zhuhai, Shenzhen and Guangzhou, the increasing number of imported malarai cases in Hong Kong and the presence of HIV infections among intravenous drug abusers in these areas.

On the prevention and control of communicable diseases, Lee said the meeting concluded that it is necessary for the participating areas to strengthen the existing epidemiological information exchange system, develop good laboratory facilities and encourage research in the prevention and control of communicable diseases including the development of new and effective vaccines.

It was also decided that the meeting will continue to be held once every two years to exchange epidemiological information and to discuss the control of communicable diseases.

Cholera Spreading in Southeast Coast Area of Hainan

90WE0111B Beijing ZHONGGUO HUANJING BAO [CHINA ENVIRONMENTAL NEWS] in Chinese 16 Dec 89 p 1

[Article by Chen Shengyang [7115 0581 7122]: "Chronic Water Pollution Leads to Epidemic: Cholera Spreading in Southeast Coastal Area of Hainan Province"]

[Text] Since early October, paracholera has been spreading in the southeast coastal area in Hainan, including Wanning County, Lingshui County and the township of Sanya. According to the latest report, 16 people had died of this disease and 82 patients have been hospitalized.

Paracholera (also known as number 2 disease) is an acute epidemic disease; it erupts abruptly and is usually

marked by severe symptoms. If the victim does not receive timely and adequate therapy, imminent death may follow. A public health worker with the Hainan Department of Disease Control explained that the epidemic of cholera occurs mainly as a result of water pollution in the coastal area, which leads to the infection of plankton in the water. In the hospital, a patient with a minor case of paracholera accounted his own experience: Several days before, he had cooked two fish, which he brought home from the local market in the afternoon, for his daughter and himself. Unexpectedly, both of them suffered vomitting and diarrhea barely 1 hour after their supper. Fortunately, their next-door neighbor is a physician. He immediately sensed the seriousness of their illness and sent the father and daughter to the hospital emergency room. There, their cases of paracholera were diagnosed and they were hospitalized that evening. The timely treatment saved them.

The incessant spread of paracholera has greatly endangered the physical well-being of the people in the coastal area. Responding to this serious threat to public health, the provincial government of Hainan has sent medical teams to infected areas, has allocated more than 300,000 yuan as special disease-control funds, and has provided large quantities of disinfectants and oral vaccines. However, Hainan had just been invaded by three powerful typhoons, number 25, 26 and 28, as well as heavy rain storms last month; the general consensus of disease-control experts is that "Epidemics frequently follow disasters." At present, we can only mobilize all the people to join in the patriotic sanitation movement, to clean our environment, to protect our water supplies and resolutely stop any illegal disposal that may pollute water resources so as to put the paracholera epidemic under control and eventually eradicate this disease.

Investigation of Virus Causing Porcine Epidemic Diarrhea

90WE0162A Guiyang GUIZHOU NONGYE KEXUE in Chinese No 5, 15 Oct 89 pp 49-52

[Article by Yue Zhengzhong (2867 2973 0022) and Xiao Daozhang (5135 6670 1757), Guizhou Provincial Veterinary Medicine Prevention and Treatment Quarantine Station, and Liao Huanfen (1675 3562 5358) and Long Yuezhong (7893 6460 1813), Guiyang Municipal Veterinary Medicine Prevention and Treatment Quarantine Station: "Investigation of Porcine Epidemic Diarrhea in Guizhou Province"]

[Abstract] Experiments begun in 1985 demonstrated an acute watery diarrhea afflicting hogs in Guiyang Prefecture, Guizhou Province to be porcine epidemic diarrhea. Though the Guiyang strain of this diarrhea caused only a low death rate (about 3.9 percent of hogs infected), it resulted in severe weight loss in mature hogs, and greatly inhibited the development of piglets.

This nearly four page article details the epidemiological and clinical symptoms of the disease, as well as the methods used to detect the corona-virus-like agent that causes it. These methods included artificial infection experiments, electron microscope observations, use of immunofluorescence methods (immunofluorescence direct and indirect methods of staining, and immunofluorescence experiments), the double antibody filling method using ELISA, and the SPA-COA method.

In a final section on conclusions and discussion, results are compared with those obtained from similar work previously done in western countries.

BULGARIA

Scientists Concerned Over Chernobyl Effects

90WE0149A Sofia NARODNA ARMIYA in Bulgarian 12 Feb 90 p 3

[Address by a group of scientists and specialists regarding the problems with medical and biological sequelae in our population following the Chernobyl Nuclear Power Plant accident in April, 1986 to Stanko Todorov, Chairman of the National Assembly: "Such is the Scientific Truth"]

[Text]Dear Comrade Chairman,

We are a group of scientists and specialists—physicians, physicists, chemists, and engineers—working in the field of radiation hygiene and safety, radiobiology, nuclear medicine, and radiology. Through you, we are addressing the National Assembly regarding a problem which has lately provoked a great deal of interest in large sectors of the population. One of the reasons is that all types of different materials have been published in a number of mass communication media, which in a number of cases have been accompanied by interpretations and commentaries by nonspecialists having nothing in common with the scientific explanation of these problems. We feel forced to turn to you because some materials which some of us have presented for publication have been inexplicably delayed and have been denied glasnost. This worries us, because issues concerning the population's health and life have an extraordinary social significance and we feel there should be neither silence nor distortion regarding them.

As it is well known, on 30 April 1986 our country's territory was globally contaminated with radioactive materials released from the malfunctioning reactor of the Chernobyl AETs [Nuclear Power Plant]. A number of measures were taken to protect the population, and a number of other measures were not, but this is a separate problem which we do not wish to discuss here. During that period, not a single one of us was an administrative head or manager on whom administrative decisions or orders affecting the whole country depended. The difficult situation of our health care system is well known, and the system for radiation protection is not an exception. Additionally, our present readiness to deal with disasters of this type is even lower than it was on 1 May 1986, but this is a different problem, also very important, which we will not discuss here.

As a result of radioactive contamination the Bulgarian population received a definite amount of irradiation from external gamma radiation and from radionuclides penetrating the organism, mainly Iodine 131, Cesium 134, and Cesium 137. Our specialists' estimate of the average dose of irradiation per individual over the first year after the accident is between 0.6 and and 1.5 millisieverts (mSv). This estimate was confirmed by the experts of the United Nations Scientific Committee on Atomic Radiation Effects. This irradiation represents about 20 percent of the internationally accepted maximum permissible doses. These have been proposed by the International Atomic Energy Agency (MAGATE) [IAEA], the World Health Organization (SZO) [WHO], the International Commission on Radiological Protection (MKRZ) [ICRP], the OON [UN], and others. They are also accepted in our country.

The radiation dose to the thyroid glands is estimated at 3 mSv for adults and 10 mSv for children which are also under the accepted maximum permissible doses.

Since the contamination of the country was irregular, and since the population did not receive sufficiently complete and clear information either, then it is possible for certain individuals to have received about 10 mSv whole body irradiation and about 200 mSv to the thyroid glands.

News items have appeared in the press about health and life endangering sequelae, monstrous genetic effects, special conditions for the accepted maximum permissible doses and so on. This is entirely unfounded. The present maximum permissible doses for radiation protection are based on very cautious scientific concepts and are calculated with such safety coefficients which so far have not been used with any single nonradiation hazardous factor.

After a radiation load received in this manner, it is impossible not to expect any early effects on people's health, such as radiation poisoning, or any clinical manifestation of individual organ or system injury, for example: hematopoietic depression, germ cell damage, benign tumors, damage of the blood vessels, cataracts, and so on. Any damage to the human fetus during the intrauterine development period manifesting itself as stillbirths, twin births, spontaneous abortions, and malformations cannot be expected. All this has been confirmed by health statistics data for the years following 1 May 1986, not only in our country, but also in all countries affected by the accident. Of course, we are not discussing here the areas immediately around Chernobyl where irradiation was thousands of times greater.

Late effects of irradiation depend on chance, that is, it is not possible to identify ahead of time the individuals in whom these effects would manifest themselves. These are malignant neoplasms which manifest themselves after long latency periods, after decades, as well as genetic effects which manifest themselves in the offspring of those who received irradiation.

Prognosis regarding cancer for our country, made with the help of risk coefficients provided by ICRP, WHO, UN, and IAEA are as follows: Over the next 50 years, eight cases of terminal and 16 cases of treatable radiation-induced cancer are expected. We must remember that at the present time there are about 15,000 deaths from cancer annually in our country, while cancer morbidity is about 120,000. The comparison is obvious.

The situation is even less defined regarding serious genetic defects. We can only point out that studies over many years conducted on the offspring of Hiroshima and Nagasaki residents who survived irradiation, have not proven reliably the presence of radiation-induced genetic defects. Remember that these people received irradiation thousands of times greater than the one received by our population from the Chernobyl accident.

Such is the scientific truth.

Lately, there has been a great deal of fuss made over the so-called hot particles and their cancerogenic effect on the lungs after their inhalation. Sober analysis of available scientific data does not provide basis for such concern. Even at the latest international symposia and reports from 1988 and 1989 dedicated to the consequences of the Chernobyl accident, hot particles are not viewed as a significant factor in the radiation effect on humans.

Of course, studies on the subject are being conducted and will be conducted. Other epidemiological studies on certain groups of the population have been planned and will be implemented as well, but scientific discussion on this or that problem should not become a source of fear for the general population. Alarming, inexcusable and obviously deliberate increase in tension is being observed.

Once again we emphasize that we have been forced to turn to you; in the presence of definite unwillingness of the mass communication media to publish our opinions, we have no other way to make them accessible to the Bulgarian people.

The above address was read at a special meeting of the Science and Education Council of the Science Institute of Nuclear Medicine, Radiobiology and Radiation Hygiene at the Medical Academy, which took place on 31 January 1990 and was signed by 46 people holding doctorates and master's degrees, by professors, first and second degree senior research associates, and specialists.

BRAZIL

Sao Paulo Meningitis Cases Again Rise

90WE0164B Sao Paulo FOLHA DE SAO PAULO in Portuguese 30 Mar 90 p 3

[Text] The 38 municipalities of Greater Sao Paulo have been experiencing an epidemic of type B meningococcic meningitis since 1988. This claim was made by the State Health Secretariat and by infection specialists. During February there were 49 cases in the metropolitan region, with five deaths; and in March the total number of cases as of yesterday was 52, with 10 deaths.

Nevertheless, according to the superintendent of the Clinics Hospital, Vicente Amato Neto, aged 62, this fact should not cause alarm, because the epidemic does not appear to be as rampant as the one that occurred in the mid-1970's: In 1974, 17,837 cases of meningitis were reported in Greater Sao Paulo alone. Amato remarked: "During that time we had in 1 day the total number of cases that we are now recording in a month. In 1989, 847 persons had the disease."

Amato claims that it is characteristic of type B meningitis to cause a lengthy epidemic, but one that attacks fewer people than the other types of the disease. The epidemic during the last decade involved types A and C.

Physicians consider an epidemic to exist when the endemic level (the number of cases that usually occur in a community) is exceeded. As of June 1988 the average number of cases reported in Greater Sao Paulo monthly ranged bwtween 20 and 40. After that month the number rose. During June 1988 71 cases were reported. "It was after that date that we began considering it an epidemic," claims Wagner Costa, 40, director of the Sao Paulo Epidemiological Vigilance Center.

The physicians' prediction is that the type B meningitis epidemic should last about 10 years. They base this on the examples of Finland, where the epidemic lasted 10 years, and Cuba, where its duration was 8 years. However, according to Wagner Costa, the Cubans began using the vaccine against the disease only 6 years after the epidemic appeared. "We just began vaccinating last year," commented Costa.

During 1989, 310,000 children received the two doses of vaccine. This year it is intended to vaccinate 2.3 million children between 3 months and 7 years of age. The vaccination will begin next Monday at Greater Sao Paulo's 633 health stations. The second dose will be given between 14 and 18 May. The vaccinated individual is not immune to the disease until 4 weeks after the second dose. Children who received both doses in 1989 need not be vaccinated again.

Study Projects Rise in Infant Mortality Rate

90WE0164A Sao Paulo O ESTADO DE SAO PAULO in Portuguese 7 Apr 90 p 10

[Text] Brasilia—Brazil could reach the year 2000 with an infant mortality rate of 35 deaths for every 1,000 births, surpassing the serious situation that occurred throughout the 1980's, when an average of 67.8 deaths for every 1,000 births were recorded. But the Northeast (where that index exceeds 100) will probably reach a total of 80 deaths per 1,000 births, well above the level set by the World Health Organization, namely, 30 deaths for every 1,000 births.

This conclusion is contained in an evaluation made by the Institute of Economic and Social Planning (IPES), in conjunction with the United Nations Children's Emergency Fund (UNICEF), after analyzing the social programs executed by the Brazilian Government during recent years. The study showed that the leading causes of infant mortality are intestinal infections (16.6 percent) and acute respiratory infections (15.3 percent), with septicemia (generalized infection), congenital problems, and prematurity also prominent. The malnutrition factor contributes 5.5 percent.

According to IPES and UNICEF, the Brazilian authorities gave priority to their programs in the South and Southeast, bringing about different levels of poverty and of access to basic sanitation and health services in all parts of the country. As a result, infant mortality proved to be 2.5 times higher among poor families, and during 1988 reached rates of 125 deaths for every 1,000 children in the urban areas of the Northeast. Among families with an income exceeding five minimum wages, during that same year the mortality rate was less than 50 per 1,000. Data relating to 1988 also indicate that, in the South and Southeast, the infant population among families with incomes lower than one minimum wage showed a mortality rate of about 65 per 1,000. And among those earning between three and four minimum wages, the rate dropped to 46 per 1,000.

The evaluation proved that basic sanitation is still one of the most important variables in determining infant mortality levels, and the lack of it can raise that rate between two and five times. Between 1975 and 1983, in Sao Paulo, when there was a larger allocation of funds for the sector, the mortality rate declined from 28 deaths per 1,000 births to six per 1,000. Nevertheless, the study concluded that over 60 percent of Brazilian children under age 4 are living under unsuitable hygienic conditions.

The document also notes that high infant mortality rates are related to the mother's degree of education: 1987 statistics indicate that the urban mortality rate was 102 per 1,000 among children of uneducated mothers.

HONDURAS

11,000 Cases of Measles; 9,000 Cases of Malaria

90WE0184A San Pedro Sula LA PRENSA in Spanish 20 Apr 90 p 11

[Text] San Pedro Sula—A total of 11,000 cases of measles and 9,000 of malaria have been reported, with health region number 3 accounting for 25 percent of the cases of the latter disease, according to the general director of public health, Marco Tulio Carranza.

The official met in this city yesterday with the heads of the number 3 region areas and departments for the purpose of "making the programs aimed at combating these diseases the best possible, so that we can optimize the resources that we have," as he noted.

Measles

The health director explained that, thus far this year, health regions 3, 5, and 6 have shown the largest number of cases nationwide. He remarked that, for this reason, the strategies that have been pursued in an attempt to check the disease are being revised.

He declared: "The measles epidemic is alarming, because in areas such as San Pedro Sula, where there are large population groups and underprivileged urban zones, the vaccination coverage has never reached levels that could be regarded as optimal."

He stressed that, to date, 11,000 measles cases have been reported, observing: "We might say that this year's epidemic is worse when compared with that of 1984-85."

He recalled that it was not until 1979 that vaccinations against that disease were started in the country. That is why, at this point, there are many adults and adolescents who have not undergone the vaccination process and have become infected.

Malaria

As for malaria, he said that there has been a significant increase in cases, particularly in region 3, which "is showing us a considerable number."

Of the 9,000 cases of malaria recorded during the first 3 months of this year, over 25 percent were reported in region 3. He claimed: "We are in a process of restructuring the Vectors Division, in order to observe and correct the action that has been taken on this disease."

Dengue

He revealed that the health authorities of Honduras, El Salvador, and Guatemala intend to carry out a joint plan to control dengue in border zones.

He emphasized: "What concerns us is that dengue is caused by four virus serotypes, and three of them have circulated in the country to date. They cause minor symptoms among the population, but hemorrhagic dengue causes death, and that is what we are trying to prevent."

JAMAICA

Measles Epidemic Kills 45

90WE0171A San Pedro Sula LA PRENSA in Spanish 4 Apr 90 p 11

[Text] Tegucigalpa—Authorities of the Ministry of Public Health are alarmed at the number of cases of measles reported in some areas of the country, despite the fact that during the first few months of 1990 alone more than 793,000 doses of measles vaccine were administered.

Deputy Minister Jose Ramon Pereira said on 3 April that there have been 3,498 cases of this disease and that 45 of the patients have died. Most of those who died were children less than 1 year old.

The areas of the country with the greatest incidence of measles continue to be San Pedro Sula, Santa Barbara, Intibuca, and La Paz. The disease has not spread to other areas to any great extent.

The deputy minister indicated that in 1989 a measles epidemic mainly affected persons over 15 years of age. There were 6,352 cases, and 124 Hondurans died of the disease.

Pereira pointed out that the principal cause of this continuing epidemic is the failure to vaccinate children. Children are not vaccinated because either their parents or the health authorities fail to arrange for it.

INDIA

Antileprosy Campaign in Tripura Seen To Fail

54500075 Calcutta THE STATESMAN in English 28 Feb 90 p 7

[Text] Agartala—The Government's performance in eradicating leprosy appears dismal despite the high incidence of the disease in Tripura's hill areas. It now seems unlikely that leprosy in the State will be completely eradicated by 2000 A.D.—the target at the national level.

The implementation of the project was hampered not due to a paucity of funds but mainly due to negligence on the part of the administration.

It was a Centrally-aided programme under the State sector which was subsequently converted into a Centrally-sponsored scheme with 100 percent financial assistance to the States. This is to control the disease through reduction of infective sources and snapping the chain of disease transmission. According to the 1981 census, Tripura has a leper population of more than 10,000.

Almost Rs 1 crore has already been spent on leprosy eradication projects in Tripura since the scheme was taken up here for implementation in 1976. An official review has revealed that treatment facilities are yet to reach the doorstep of all registered patients. This is because posts of many paramedical workers have not been filled up. There are instances of serious delay in creation, as well as non-utilization, of infrastructural facilities such as urban leprosy centres, temporary hospitalization wards, survey, eradication and treatment centres.

Implementation fell short of targets. Detection was from 12 percent to 78 percent, registration was from 12 percent to 80 percent and shortfall in discharge of patients was from 63 percent to 69 percent during the past several years.

Though the programme envisaged microscopic examination of skin and nasal smear of lepers, this aspect of treatment was not carried out owing to vacancies in the post of technicians. A lack of ample health educators at the leprosy control units affected health education. Survey of households and examination of family members to detect cases is one of the most important objects of the programme. During the past 10 years, exactly 61 percent of the State's population were examined, though the programme envisaged completion of survey of the entire population in each five-year cycle.

The official review report also states that in a particular year, the Centre was informed by the local administration that 424 patients had been released from the leprosy ward of the Government hospitals in West Tripura district. But it was found later that the Centre was baffled since only 10 cases were actually discharged as "disease arrested." In the remaining 414 cases, the disease was neither arrested nor cured as earlier reported to the Centre.

Ulcerative Fish Disease Threatens Rural Economy

54500076 Calcutta THE STATESMAN in English 7 Mar 90 p 3

[Text] The ulcerative disease syndrome affecting fish had given a serious jolt to fish farmers in the State and had caused a setback to the programmes under the Seventh Plan, according to the State Minister for Fisheries, Mr Kiranmoy Nanda, in Calcutta on Tuesday. There was an apprehension that contamination of water resources, a probable cause of the disease, might damage the rural economy as a whole, he said.

Mr Nanda, who was speaking at a two-day national workshop on the ulcerative disease syndrome, hoped that the scientists and aquaculturists would discuss the issue in depth and recommend a course of action to tackle the malady.

Mr S. Bannerjee, the Secretary, State Fisheries Department, said that during the past year the incidence of disease had shown signs of abatement but was a matter of concern for the nation. He said that the need for interaction between scientist and administrators resulted in organizing the workshop with the collaboration of the Government of India's Ministry of Agriculture. Participants from 16 States were attending the workshop. Mr K.M. Joseph, Fisheries Development Commissioner, delivered the keynote address.

According to literature circulated at the workshop by the Central Inland Capture Fisheries Research Institute, Barrackpore, the disease had been a cause for concern to the Asia-Pacific region since 1972. The CICFRI had been monitoring the disease since its outbreak in 1988 when there was panic among fishermen and the public. In Bangladesh the disease occurred in February 1988 in the Padma, Meghna and Jamuna and adjoining waters causing loss to commercial fishing.

The institute does not rule out the entering into Indian waters of diseased fish from Bangladesh affecting eastern and north-eastern States. The exact cause of the disease is yet to be proved. Studies have shown that the disease occurs during the dry seasons and that the outbreak was high in waters of low alkalinity and hardness and was linked to periods of heavy rainfall in more alkaline waters. The remedial measures as recommended by the CICFRI study is based on the application to water of lime, potasium permanganate and controlled use of anti-biotics.

ISRAEL

Meningitis Epidemic in the North

54004509A Tel Aviv HA'ARETZ in Hebrew 11 Feb 90 p 1

[Article by Nurit Kahana, 'Edna Aridor et. al.]

[Excerpts] A new outbreak of meningitis took place the day before yesterday in the Arab village of Nahaf in the Western Galilee. In the course of it, a four and a half-year-old boy died and a 14-year-old girl is hospitalized in critical condition. Two other children, ages 12 and 15, are hospitalized in serious condition at the hospital in Nahariya. Over the Sabbath, 10 other children were brought to the hospital with high fevers. Three of those turned out to have meningitis. Dr. Rafi Talmor reported that the 10 were in isolation.

Many of the 6,000 residents of Nahaf were already immunized yesterday by the staff of the health ministry in 'Akko who were sent to the village . A special effort was made to immunize those residents who had come into contact with the sick children. [passage omitted]

Other patients infected with meningitis also came to the hospital in Nahariya yesterday. Hoda 'Abd-al-Ganam, age 14, is hospitalized in critical condition along with the uncle of the deceased, Muhamad Matar, 13, and another boy in serious condition.

Minister of Health Ya'aqov Tsur, and Director General of the Health Ministry Dr. Moshe Mashia appointed a special staff yesterday to deal with this new outbreak of the deadly disease. It may be remembered that a previous outbreak of the disease in August caused two deaths. [passage omitted]

Symptoms of the disease include high fever, headache, and a rash. At this stage, there is no vaccination for the microbe. In the United States, a vaccine has been developed for the meningococcus found in Africa and the Middle East which belongs to Group C. The microbe in Israel belongs to Group B. [passage omitted]

The head of health services at the Health Ministry, Dr. Vera Adler, pointed out that when the first report of a case of meningitis comes through, staff from the health department in 'Akko go to the village to examine the population and provide preventive medicine for those adults and children who have been exposed to the children with the disease. Dr. Adler added that there are clear instructions according to which in every case preventive medicine is to be given immediately to the nearby population.

Livestock Affected by Malta Fever

54004510A Tel Aviv HA'ARETZ in Hebrew 27 Mar 90 p 1

[Text] In recent weeks, sheep growers have been worried about the spread of Malta fever among their flocks. Blood and skin tests recently done at the Veterinary Institute in Bet Dagan on 5,500 sheep and goats from Yavni'el and the surroundings, found that 1,265 animals (23 percent) were affected by Malta fever ("brucella melitansis").

The sick sheep were immediately sent to be slaughtered under veterinary supervision, and their owners will receive compensation from the Ministry of Agriculture—up to 125-250 new Israeli shekels per animal.

The director of veterinary services at the Agriculture Ministry, Dr. Arnon Shimshoni, told HA'ARETZ that in view of the high percentage of sheep and goats affected by Malta fever, all the herds throughout the country will be checked at least once a month, in order to have the sick ones sent to slaughter. A flock will be declared clear of disease only after passing three consecutive tests without suspicious findings.

The Malta fever may spread from sheep and goats to people through the brucella melitansis virus. Israel occupied the fourth place in the world in the rate of human contamination, after Malta, Quwait, and Jordan. In 1989, 289 people came down with Malta fever in Israel.

The scope of dissemination of Malta fever in the West Bank and Gaza Strip recently marked a world record: 32 people affected out of every 100,000 residents (as opposed to 7.2 cases per 100,000 residents in Israel).

The disease is difficult and long, and it usually causes disability because it affects the joints, heart muscle, and liver. At least one death from Malta fever has been recorded in Israel in the past six months.

Veterinary sources yesterday said that it is reasonable to assume that the results of the tests on Yavni'el sheep indicate that the disease has spread to the entire country. Consequently, of the 350,000 sheep and goats in the country, it is possible that some 80,500 suffer from Malta fever and will have to be destroyed.

The same sources warned that the Treasury has not yet approved a budget to fight the fever, except for the experimental testing campaign for the Yavni'el flocks. The veterinary services' information plan, which was sent to the Treasury three years ago, has yet to be approved and, according to the sources, the services suffer from a 20-percent shortage of personnel.

OMAN

Locust Outbreak Contained

54004508A Muscat TIMES OF OMAN in English 29 Mar 90 p 7

[Text] A large outbreak of locally bred locusts was contained just in time last week before it developed into the gregarious phase, the swarm stage that is often lethal to agriculture, plant protection expert, Dr 'Abd al-Mun'im al-Mjeni said.

"The problem was discovered on March 10 in the al-Sharqiyah region during a routine weekly survey by extension teams that assist farmers. We had to resort to spraying. However, it was not serious enough to require very costly aerial spraying, most were still in the ground in lava form. The eggs hatched as a result of the recent rains.

"It was fully contained on March 18 after twice-daily applications for a week. Mostly they were in large numbers of the solitarious phase. However, some did show signs of gregarious formations. We do not totally rule out the possibility of outbreaks in other areas and we are still carrying out surveys."

Potential

Oman has a potential for serious locust attacks from locally bred insects and also because it is on the migration path, Dr al-Mujeni said. This situation calls for routine surveys with particular vigilance after the rains as moisture is needed for laying and hatching locust eggs and the nymphs (young) require large amounts of vegetation for feeding.

Last year there was a near-miss when major locust outbreaks in Saudi Arabia and the Horn of Africa posed a threat of an invasion of Oman and experts at the Ministry of Agriculture and Fisheries went on full alert.

In February 1989 the government distributed 32 tonnes of insecticides to agricultural centres throughout the country for spraying in case the swarms came. Fortunately they did not because the wind carried them away as they change directions with the wind.

The Sultanate is on the crossroads of two major flight paths. One from the east comprising India, Pakistan and Iran or from the north-central region across the Arabian Peninsula, Sudan and Ethiopia.

Oman is also on a migration path from the Horn of Africa across the Indian Ocean to the Indian subcontinent.

The government recently bought 20 units of the latest spraying equipment which was used in the Sharqiya operation. These truck-mounted units can spray at the very efficient rate of 7 minutes per hectre.

Dr al-Mujeni said new anti-locust chemicals were being developed with low environmental impact.

Their persistence in the atmosphere is shorter and toxicity to mammals is lower. However, it is the accumulative effect to mammals that has always been of concern.

PAKISTAN

Special Reports Examine Health Issues, Prospects

54004706 Lahore VIEWPOINT in English 15 Mar 90 p 6

[Text] Expectations that a new national health policy may begin to operate without the usual delays invites urgent attention to the myriad problems that impinge on the nation's health. Always far from satisfactory because of endemic mass poverty, the people's health has deteriorated rapidly over recent years as a result of many factors, some of which are neglected badly. The plans presently under consideration seem, as always, to be guided by good intentions; but experience has shown that usually all Government's welfare schemes function properly only at the higher level, where they cater to the needs of Ministers and senior bureaucrats, but the plans tend to fizzle out when they reach levels where they are meant to provide for the requirements of ordinary citizens. Lack of funds is the common excuse given for such failure; but lack of interest suggests the real explanation.

The prime causes of an easily perceptible lowering of health standards in Pakistan can be listed without difficulty by any intelligent schoolchild. Perhaps the biggest single factor is the country's unchecked population growth—estimated at over three percent. This problem is often swept under the carpet, although no-one can deny that increasing national resources just cannot keep pace with the frightening annual increase in our population. As a result of authority's inability or refusal to help control population growth, our cities are getting overcrowded, and as slums proliferate living conditions sink to still lower levels. Sanitation worsens, all-round pollution prospers, the availability of potable water decreases, and essential food not only gets scarcer for the mass of the people but adulteration destroys much of its nutritional value. Increasing unemployment and inflationary prices add to the people's woes. Then, the induction of hard drugs on a scale where one out of every fifty Pakistanis is an addict threatens to destroy the social fabric and damages public morale. National morale is further eroded by the prevailing insecurity of person and property, the rampant corruption and the absence of any tangible effort by the elected governments to put things right. All this generates a psychological strain which adversely affects the people's physical and mental health.

While these and related problems must receive earnest attention, the main task before the health authorities of providing medicare for all must be so tackled that available resources are put to the best use—and an honest effort is made to augment the wherewithal. It seems necessary to stress that priority must be given to the less spectacular but equally essential task of evolving measures that can check the spread of diseases through preventive medicine, although this does not mean that curative efforts can be relaxed. In regard to both these essential facets of any health programme, neglect of the countryside must at last be ended—and not only in

official files but on the ground, so that the basic health needs of the majority of our people can be met. It should be realized that the myth of our villagers' natural good health should have been buried long decades ago; the rural areas are subject to the same poor living conditions that are common in the cities.

Out Governments must try to create a network of well-equipped and properly staffed clinics and hospitals where easy access is made possible for all those who stand in need of medical aid. The people will thereby be saved also from the clutches of charlatans and quacks who take advantage of the people's ignorance to fleece them without offering any help or succor. Further, in working out future health plans, policy-makers should not depend too much on the privatization of this sector, because extension in this direction can only help the few who can afford to pay the high cost incurred in private hospitals or are covered by some health insurance scheme. The rest will depend on Government hospitals—where they should be required to pay only nominal fees and expenses—and this category forms the vast majority of our people whose welfare must not be neglected.

Article Reports on 'State of the Nation's Health'

54004709 Lahore VIEWPOINT in English
15 Mar 90 pp 10-13

[Article by Zafaryab Ahmed]

[Excerpts] Health for all by the year 2000 is a nice, comforting sort of slogan. But the millions of ordinary people who now have to depend on Government hospitals and health services have every reason to be skeptical. For them, the absence of proper medical treatment is one of life's many deprivations.

The bigger public hospitals are all located in a few cities; medical facilities in the mofussil and the rural areas are practically non-existent.

The condition of the public hospitals, the only places where people can get free medical care, can at best be described as terrible: they are filthy and overcrowded, with patients often put in the verandas and even being forced to share beds.

The outpatient departments of the hospitals always have a long line of people: the doctors on duty are a handful. The attention that patients get is, therefore, perfunctory. In the wards, patients groan for care and kindness. They are left unattended in unhygienic surroundings, sometimes even after major operations. Their relatives crowd inside the hospitals; their presence, which otherwise might be considered unjustified, proves essential in view of the lack of care from hospital staff and also because a relative or a friend has to be frequently sent to fetch a medicine from the chemists since the hospitals are—or made to appear—perennially short of life-saving drugs and blood. Nurses are often rude and inattentive in the general, non-paying wards and doctors hard to get to the bedside of a patient going through a crisis.

Emergency or casualty wards where specialist help is needed are mostly left to interns or young doctors.

Stories about what can happen in hospital operating theaters are legend—of how some surgeons can open up your stomach and then demand that a certain fee be paid. It is also a common complaint that many top doctors quietly advise patients to see them in their clinics if they want proper treatment—and pay the prescribed fees. The link up between Government hospital doctors and private hospitals, which have mushroomed with the flood of illicit money around, and even pathological laboratories is also common knowledge.

Of course, the private hospitals are well equipped and patients there get every possible care and comfort. But they cost money—the kind of money which even those in the higher income brackets cannot afford in case of prolonged or serious illness. For the poor and those with limited means, who are not in government service or are otherwise without a medical cover, getting cancer or having to undergo major surgery can be crippling, physically and economically. For them public hospitals are the only recourse and no Government has paid much attention to improving facilities in this area.

These appear like generalizations. Instances can always be quoted of dedicated and honest doctors and nurses. But the fact is that the State has failed to provide a minimum health cover to the have-nots.

We have increased the number of medical colleges but have not increased the number of hospitals. We train our students around hospitals, with modern equipment and patients generally capable of explaining their problems, and then we expect them to go and work in villages.

The health services are riddled with constraints and contradictions. Like the provision of other basic needs, health too has a low priority in our budgetary allocations and development efforts. The brunt of this is borne by the poor. A person's influence or connections determine his ability to benefit from the health services. Those without any such means have to wait for long hours in crowded and suffocating wards.

On paper, we have a five-tier system of health care. At the bottom, there is a dispensary called a Basic health Unit for the treatment of simple disease, for immunization and prevention of communicable diseases. There is hardly any unit which is properly equipped and delivers the services it is meant to. To every four basic health units, there is a Rural Health Center with diagnostic facilities and 10 beds equipped to treat minor emergencies, a mother and child health clinic and obstetrics facilities. At the tehsil level, there is a 60-bed hospital supposed to have a junior specialist and equipped with surgical facilities. The district town has a 250-bed hospital, which is supposed to have specialists and senior

doctors on its staff, geared to perform surgery by specialists. At the top is a 1,000-bed teaching hospital with all available facilities for teaching, training, treatment by specialists, field surgery and intensive care. The lower four tiers do not function properly because of inadequate equipment and staff, and the teaching hospitals are inadequate for the needs of the burgeoning population at our urban centers.

Five-Year Plans

Despite the commitments of the first four five-year plans, no serious attention was given to improving the health services till the mid-70s. Even the Bhole commission (1946) guidelines were not pursued. What existed at independence had already started deteriorating by the 50s. The Fifth Five-Year Plan was the only document that addressed the issue in the manner that it needed to be. However, the emphasis remained on the curative side. But the plan targets could not be met. The two following plans made lofty commitments but ironically the budgetary allocations for health fell from 1 percent in 1978 to 0.6 percent in 1988.

Indifference and insensitivity is so evident at the State level that doctors talk about nothing but their pay structure and facilities. They can't be expected to remain immune to the dominant values in society. Except for students and young doctors, no one seems worried about the ordeal of poor patients. Doctors working in Government hospitals treat their patients at best as a burden and those in private polyclinics treat them as clients in the manner of any other businessmen. Most of the senior doctors do not do their duties properly—neither in the colleges nor in the hospitals. Their private patients get preference in benefiting from hospital facilities. A specialist can get free tests done from a hospital. They charge consultation fees ranging between Rs 150 and Rs 300 and may add as many tests as they want.

An EGG or some other test of the sort is a must on first visit to a heart specialist. That means an additional Rs 100. A vast majority of specialists in various branches are in fact doing the job of general practitioners. They violate the established norms of a referral from a physician before entertaining a patient. There are specialists who attend to no less than 150 patients a day. Some of them work in their clinics from 5 p.m. to 12 midnight. How can one expect them to prepare lectures for the next morning and teach their students or to have time to read or undertake research?

Some of these problems were put to the Health Secretary, Punjab, Chaudhry Ashraf, whom I visited in his office. After some delay and hesitation I was ushered into his presence. He was discussing embezzlement of patients' diet money at one of the Lahore hospitals with the Medical Superintendent concerned.

The Secretary introduced me to those present and assured me that I had reached there at the most opportune moment, since I would have the opportunity to discuss all that I wanted to in the presence of those who had a long affiliation with the department.

I asked him if he was satisfied with the existing structure of our health services. He said: "We do not claim that our health system is perfect. There are deficiencies which are within our control. Some are not. The service is deficient in many areas. There is no proper cover in our rural areas, the hospitals in the cities are deficient. The expansion of health service has not been able to keep pace with our requirements."

VP: You are the Health Secretary. What is the policy under which you are running this Office?

HS: This is not a simple question. It needs a detailed discussion. Have you been to a hospital recently. Why don't you go with Dr Shaukat Ali Shah (of the Services Hospital) and have a round of his hospital? And we will meet again at 3 o'clock. Then we will be able to talk about this.

Passing the Buck

I had a feeling that the Secretary was simply passing on the buck. This turned out to be true. At 3 o'clock when I rang to check, I had to wait because one of the drugstore owners contracted for supplying drugs to another hospital had made a representation against the particular hospital I was supposed to visit that drugs worth Rs 1 crore were being purchased from a drug store whose credentials were fake and which did not qualify to be a contractor. The way the Secretary disposed of the case was an experience of its own kind. I was finally unable to meet the secretary.

The visit to the hospital turned out to be a guided tour with the Additional M.S. responsible for administration. Before setting out for the round of the hospital, it was difficult to get a correct picture of the situation or make queries from the staff. [passage omitted]

The conversation with the Medical Superintendent was equally revealing. He had no concern for the increasing needs of the health cover and shortage of facilities.

About the problems of a health cover, he said: "The health service should be insured. By this we can solve lots of problems. The consultation fee will become uniform. Some discipline can be introduced through this system. Both junior and senior doctors will benefit. I do not think that people can't afford insurance or there is anyone in Pakistan who is poor. This vendor outside the hospital earns more than I do."

To stress his point for an insurance system, he said: "Increasing the health budget is no solution. Let us suppose it is increased to Rs. 1 billion from Rs 100 million. The demand and needs will increase in the same proportion. So will pilferage and corruption. If health is insured and we have a referral system, we can bring rationality to our medical service."

When I pointed out that in the Health Secretary office's there was an application against him for having only one contractor, the M.S. replied that "the complainant is corrupt and is blacklisted—incidentally, he was one of the contractors for Mayo Hospital—and was convicted during the martial law regime. He is a big fraud and knows many influential people. He approached me through his contacts to get the contract, but I did not succumb to his pressure."

While talking about his own hospital which caters for Government employees, he said: "There is no shortage of doctors, equipment or skills. The hospital is over equipped. Where we need one thing, we have two. But there is no procedure. At least 200-400 cases of casualty come to the hospital every day. We give medicines to all the patients who come to the emergency ward. At least a hundred of them are serious cases. To deal with the situation, we have almost all life-saving drugs in our emergency ward."

Food Cheating

I intervened: "You were saying that out of the total number of 1,000 patients, only 60 percent patients were taking their meals at the hospital while the hospital was being charged for all 1,000, how about the distribution of medicines?"

"In the case of medicines, those who can afford are asked to buy their own medicines. Those who are poor, for them we have the Zakat fund. The only thing that a person has to do is to get a certificate from the chairman of the Zakat Committee of his mohalla."

Then, in a patronizing tone, he said: "We provide the poor and the needy with all the medicines that they need. There is a social welfare department that also helps the poor, mostly non-Muslims who are not entitled to Zakat."

On a second independent round of the same hospital, Viewpoint Found that mostly it was "sifarish" and influence of the patients instead of his/her paying capacity that determined a doctor's decision about a person's entitlement to free treatment. One patient said that it was not easy to get a certificate from the Zakat Committee Chairman.

There are ways and means with which a hospital administration can manipulate Zakat funds, and its recommendation also works in attaining a certificate from the Zakat Committee. In a situation like ours, who wouldn't be tempted to use this procedure for political patronage? Only those people are entitled to treatment whose earning is not more than Rs 400. On finding this out, I understood the truth of Dr Shaukat Ali Shah's assertion which had earlier amazed me, that no one is poor in this country.

The Medical Superintendent of another Government hospital appeared to be quite reasonable. He was not reticent. He talked about his problems openly, mostly administrative ones. "Everybody knows what a mess our health sector is in. The present situation has been precipitated because of neglect in the past. For the past 30 years, the problems have been highlighted many times. People have talked about them but nobody has done anything to improve the situation," said Dr Muhammad Akram Sheikh, Medical Superintendent, Sir Ganga Ram Hospital.

"The basic problem is shortage of funds. If we have funds we can't make appointments even for posts in Grade IV. We could do that a year or so ago but for the first one year, there seems to be no clear policy for recruitment."

There is a proposal to affiliate district hospitals with the teaching hospital. Will that solve the problem or complicate it?

"This will complicate the problem further. District hospitals should be kept independent. There is a difference in the working of the two places."

To find out more about the health service and teaching of medicine, we tried to contact almost all the principals of medical colleges in Lahore. But they kept on putting off appointments. Perhaps they were being cagey or couldn't find time to spare from their private practice.

Minister Outlines New Health Policy

54004706 Lahore VIEWPOINT in English
15 Mar 90 pp 13-14

[Text] Federal Health Minister Amir Haider Kazmi talked to Viewpoint about the new health policy drafted by the present Government and which he said had the backing of all the provincial governments. The Minister said:

Our aim is to provide Health for all by the year 2000. We have framed our health policy keeping this objective of the World Health Organization in mind. We have decided to benefit from our indigenous methods of treatment and refine them in the light of developments in modern science.

The Health Policy is an exhaustive document. It covers issues ranging from those of paramedics to courses and syllabi in our medical colleges. We have tried to get the maximum out of the existing system. For that the policy envisages fundamental changes at the district level, the third tier of our health system.

We are up against odds because all the targets that we had previously set in our various plans were never achieved. This is an unfortunate situation. We have today around 6,000 or so unemployed doctors. We plan to make jobs in rural areas more attractive.

After forming our Government, we tried to understand what went wrong in the past. One of the things that struck us was that responsibility for the teaching of medicine was totally with the Government. We intend to

encourage the private sector to set up medical colleges and join in the effort and share the burden. We also intend to introduce a fee structure in which students will be charged according to their paying capacity.

By bringing in the private sector, we will be able to divert our resources for expansion of the health cover.

We also want our people to develop a habit of paying something for their treatment. No developing country in the world provides totally free medical treatment to its people. But these user charges will be made only from those who can afford to pay. By no means can a government in a country like Pakistan afford that all its hospitals provide all the facilities free of charge. Money collected through this can then be used for the expansion of our health services.

We have never been able to spare five percent of our GNP for health, for which we have made a commitment to the international community. To generate resources of that kind, we can either impose new taxes or put cuts on existing expenditure.

In a situation when a government has to borrow to provide subsidy on wheat and cotton, how can we think of levying additional taxes? The choice that we are left with is to generate new resources.

Then we have this problem of pharmaceuticals. We do not have any basic industry. Exorbitant prices are charged for drugs. It is true that the Government had a monopoly over pharmaceuticals, but it has to yield to pressures at times. To provide medicines to our people at a reasonable price, the Health Ministry, with the help of 68 top doctors of our country, has prepared a health formulary of 430 medicines. Government is considering various measures to control prices. More competition in pharmaceuticals can be one measure. Another can be the government itself taking the initiative in this field. Restricting the import of drugs to "research products" can also be useful.

So we have taken a broader view of this problem. By these measures, we will not only be providing drugs at a lower cost but also be able to establish a new industry. At the moment, drugs worth Rs 7 billion are being used in our country.

Quackery too is a big problem in our country. According to some estimates, there are at least 40,000 quacks who are not only cheating people but also poisoning them. You see them everywhere in the buses along the roads. There is hardly a single road in our country where walls do not advertise "guaranteed cures". People do go for these advertisements which is quite worrying. To fight quackery, we are planning to develop Unani, Tibbi and homeopathic medicines on scientific lines. If China can develop and benefit from its traditional medical practices, why can't we? This will help to reduce our dependence on foreign medicine and drugs.

The biggest complaint about our hospital services is regarding the shortage of drugs. This is despite the fact that the hospitals purchase drugs worth crores of rupees.

Our own findings and reports in the Press reveal that most of the drugs either are not purchased or are stolen and recycled into the market. The number of people and the kind of people involved in this racket is amazing. Besides the substandard drugs, this was one of the reasons for the drawing up of a national formulary. We hope that this measure will increase the capacity of our hospitals to buy more drugs and serve more people within the existing budget.

Another thing that we have in mind is to make use of pharmacists. They are still there but are not being properly utilized. We think that properly trained pharmacists will reduce our dependence on patent drugs.

The Government aims at decentralizing the health system. Most of the malpractices in our health services are because of the centralized nature of the service. It is not possible for the federal or a provincial government to give the kind of attention which the health services need. Now what is happening is that the District Health Officers are provided most of the facilities required at the district level. But the vehicles and other facilities given for immunization are being used for personal use. There has to be a check on it.

The new health policy envisages a democratic set up. Instead of the DHOs there will be a District Health Board run by a District Health Committee constituted of MNAs and MPAs of the area and local eminent doctors. This committee will be responsible for the disbursement of funds and also monitor all health facilities in their area.

Official figures show that there are health facilities for 85 percent of our population. In the national budget, allocation is made for all the heads show in the figures. But the actual picture is not this. Most of our Basic Health Units are not functioning. the money is given to the departments concerned. There is so much corruption that not a fraction of it is actually spent on health.

We have eliminated the category of DHO. If a provincial government wants to nominate a health officer his activities will be monitored by the committee. Now if the facilities are not available, people can hold their MPAs and MNAs responsible.

Then, there is the fact that, on the one hand, we have a shortage of doctors, and on the other, we have more than 6,000 unemployed doctors. The main reason for this is that our doctors do not want to go and work in the villages. They do not find it attractive. Then the parents have different expectations from their children. For instance, my parents wanted me to become a doctor not because my father was a doctor or we are a family of doctors. The reason was that a doctor in those days, even today, enjoys respect in society. He could make money, and had a place in society. Opportunities in the cities

have now lessened but a job in a village not only takes a doctor away from the city but shatters all the dreams that he had as a student.

We have studied the problem. The doctors do not have accommodation in the rural areas. If a doctor has children, where shall he send his children for education? We have decided to bind those doctors who seek admission on the quota of underdeveloped areas to work in rural areas for at least two years. They will require a certificate from the local health board for a Government job. The health policy does not aim at forcing its decision to work in villages on doctors. Someone else who will like to set up a private dispensary in a village will be provided not only with dispensary but also a loan to build a house. The Government will give him a stipend for four years—Rs 4,000 in the first month, Rs 3,000 in the second, Rs 2,000 in the third and Rs 1,000 in the fourth. This will be on top of what he earns from his patients. The period of four years is a reasonable period to establish a private practice. The government will not take anything from their private practice incomes.

We want our experts in the profession to sit in the district hospitals so that the country people can also benefit from the achievements of modern medicine. The new policy provides incentives for that as well.

As far as the teaching of medicine is concerned, we want to change the syllabus. It is out of tune with our reality. We intend to set up a committee to prepare a syllabus in accordance with the needs of our country and the advancements that have taken place in the field of medicine.

We increased budgetary allocations this year from less than one percent to 1.6 percent. That we could do by putting some cuts on other expenditure. As I said, new taxation is not possible. We have other plans to generate funds to enhance our health services.

The salary structure of doctors will also be revised. Within four months of the approval of our health policy, we will submit the new structure for approval to the Pay Commission.

The policy that we have prepared is for ten years, and if we are able to put to use all the resources allocated for health services, we will be able to meet our commitment of health for all by the year 2000. What makes me confident is that this is the first policy that has the support of all the provincial governments.

UNITED ARAB EMIRATES

Folk Medicine Banned

54004510 Dubayy KHALEEJ TIMES in English 4 Apr 90 p 2

[Text] The government has banned the sale of traditional medicine called "Bint al-Dhahab" (daughter of gold), which is commonly used in the United Arab Emirates (UAE) to treat colic in infants.

The announcement was made in Dubayy yesterday by Jasim Darwish, secretary-general of the United Arab Emirates (UAE) municipalities.

The action was taken following a report from the al-Shariqah Municipality and some laboratories that it contained 70 percent of lead. A leading pediatrician, Dr 'Abdallah al-Khayyat of Dubayy's al- Wasl Hospital, had also identified it as a major cause of lead poisoning among children.

All stocks of the medicine will be withdrawn from the markets by municipalities in their respective emirates. Mr Darwish appealed to doctors and other health and medical agencies to educate the public on the harmful effects of the medicine.

The medicine consists of pieces of some rocks which shine like gold. It is imported from some parts of India and is given in powder form, mixed with honey, or butter, in very small doses. Parents take it on a fingertip and let the infant suck it, as a cure for colic.

Doctors say lead poisoning, specially in infants, can prove fatal. It can cause anaemia, kidney problems, mental retardation, eye and brain damage.

CANADA

Ontario Government Announces Extra Funds for Health Care

54200040 Toronto THE GLOBE AND MAIL in English 7 Apr 90 p A19

[Article by Christie McLaren]

[Text] The Ontario government is loosening its purse strings to spend an extra $78.5-million this year on hospitals, home-care programs and other health-care agencies, Health Minister Elinor Caplan has announced.

The province's 223 public hospitals will now get a 9.7 percent increase in financing for the 1990-91 fiscal year, as opposed to the 8.7 percent that had been promised last November, Mrs Caplan said yesterday.

The Ontario Hospital Association—which has been lobbying heavily for additional money—welcomed the announcement but said it is still not enough to cover costs.

"Ontario hospitals are still going to be faced with very difficult choices this year," Beth Patrick, a spokesman for the OHA, said in an interview.

Hospitals must dig deeper into their pockets to pay for two new programs introduced by the provincial government this year—pay equity and a new employer health tax, Ms Patrick said.

Pay equity—the program designed to ensure that women get equal pay for performing work of the same value as men—will cost the hospitals an estimated $45-million this year.

The hospital association will try to convince the government to pay for this extra cost, Ms Patrick said.

The employer health tax will cost hospitals about $38-million, she said.

Fifth Case of Typhoid in Southwest Ontario

54200038A Ottawa THE OTTAWA CITIZEN in English 22 Mar 90 p A14

[Text] LONDON, Ont.—A fifth case of typhoid fever has been reported in southwestern Ontario.

Two cases have been identified in London, one in Sarnia and two in the Kitchener-Waterloo area, London's district health officer reported.

The typhoid can be traced to lapus, a Portuguese shellfish.

Milk Blamed for Outbreak of Salmonella in Quebec

54200039A Ottawa THE OTTAWA CITIZEN in English 22 Mar 90 p A13

[Text] Chicoutimi, Que.—Unpasteurized milk is causing an outbreak of salmonella poisoning in the Saguenay region north of Quebec City, health officials said Tuesday.

Dairy farmers gave the milk which, unlike milk sold commercially, was not pasteurized, to friends and relatives.

Salmonella poisoning causes high fevers, chills, diarrhea and headaches, but is not generally life-threatening.

"There have been 80 cases of salmonella poisoning reported within the last few weeks and 25 of these had to be hospitalized," said Dr Paul Desmeules, director of the community health at Chicoutimi Hospital.

High Rate of Deformed Babies, Miscarriages in Quebec Town

54200034A Windsor THE WINDSOR STAR in English 15 Mar 90 p B1

[Text] Quebec—A nuclear power station is not suspected of causing remarkable high rates of deformed babies born in the town of Gentilly, Quebec, the provincial environment minister said Wednesday.

Instead, Pierre Paradis pointed the finger at one or more unnamed industries in an industrial park in the west end of the town, about 150 km southwest of Quebec.

Paradis said he first learned of the high incidence of deformed babies and miscarriages in a report he received in January from a commission investigating toxic waste disposal in the province.

Evidence in the report suggested that Gentilly II, Quebec's only nuclear generating station, was not to blame.

"The Charbonneau commission was not aiming at Gentilly as a potential source of the problem, they were aiming at other pollution sources in that area," Paradis told reporters at the provincial legislature.

"We're not excluding it absolutely but the report does not make any allusions that it might be the nuclear station."

Paradis was making his first public comments on the high rate of birth defects in the town and surrounding area since they first came to light last week.

Paradis suggested prospective parents should give a second thought to having children.

"You can only put yourself in the shoes of parents who live in an area where the odds are higher than anywhere else," he said.

"There is nothing more important to parents than to give top priority to the health of their children. So in these circumstances, where there is a certain amount of doubt, you act with the maximum amount of prudence."

Three babies in Gentilly were born without anuses last summer out of a total of 174 births in 1989; in the general population only one in 5,000 children is born with the condition.

Six other local babies are known to have been born with deformities in the past three years.

An abnormally high rate of miscarriages has also been noted.

Similarly elevated levels of deformities and miscarriages have occurred with area livestock, especially sheep.

Paradis said his department as well as the health ministry is investigating the problem and compiling comprehensive statistics while also trying to pinpoint the cause.

"The source of the pollution is now under investigation by environment officials so I don't think it is in the public interest or the investigation's to reveal who it is."

Survey Shows High Prevalance of Diabetes Among Some Indians

54200033A Windsor THE WINDSOR STAR in English 16 Mar 90 p C10

[Text] Guelph, Ont.—Researchers at the University of Guelph want to conduct a national study of diabetes among native Canadians after alarming statistics showed a high prevalence of the disease in some regions.

Diabetes is seven times higher in Indians living in specific regions compared with the general population, says epidemiologist Susan Evers.

The prevalence of the disease has increased steadily in the last few decades. In certain Indian populations, half of those over 45 are diabetic.

Evers is putting together a proposal for a national study with Kue Young of the University of Manitoba and Emoka Szathmry of the University of Western Ontario.

A survey done by the three several years ago showed Indian populations in the far North had little or no diabetes, those in northern communities had a slightly higher than normal prevalence (two to four percent) and those in southeastern areas showed a high prevalence (14 percent).

The researchers have proposed screening for diabetes in 12 Indian communities to determine how prevalent the disease is and to develop prevention programs.

'Deadly Form' of Canine Distemper Found in British Columbia

54200043 Vancouver THE SUN in English 12 Apr 90 p B1

[Text] A deadly form of canine distemper is hitting an increasing number of dogs in the Lower mainland, a representative of the B.C. Veterinary Medical Association says. "Several" cases have been reported in North Burnaby, Coquitlam and Port Coquitlam since late march, Adrian Cooper said. Puppies and older dogs are particularly susceptible to the disease, which is prevented by vaccination, he said.

FINLAND

Vaccination Effort Credited in Ending Rabies Epidemic

90WE0159A Helsinki HUFVUDSTADSBLADET in Swedish 8 Mar 90 p 8

[Unattributed Finnish News Agency article: "No Rabies Cases Following Vaccination"]

[Text] The antirabies vaccination campaign has had excellent results in Finland. The latest rabid animal was found in Pyttis on 16 February 1989. Since that time, no rabies cases have been encountered among the animals tested within the 1,700 square kilometer area of infection, or within the 7,000 square kilometer area surrounding the area of infection.

The State Institute of Veterinary Medicine has tested a total of 630 martens, foxes, and badgers from the area.

The three vaccination campaigns were conducted as a joint effort by the Wild Animal and Veterinary Medicine department authorities. A great deal of the practical work involved in putting out food containing the vaccine was performed by local hunters.

During the course of the campaigns, a total of almost 190,000 pieces of bait containing vaccine were distributed over a 12,300 square kilometer area. These campaigns were conducted in September of 1988, April of 1989, and September of 1989.

The Ministry of Agriculture and Forestry's veterinary department has announced that vaccination for rabies is still mandatory for hunting dogs, and for dogs used by the government.

The ministry also recommends that other dogs and cats which are active outdoors should be vaccinated. The vaccination of cattle is not considered to be necessary unless new cases of rabies are reported.

Rabies in the Soviet Union

Future plans have been made to keep a stockpile of deep-frozen food containing vaccine to combat any future outbreaks. The stockpile is intended to cover an area of approximately 1,600 square kilometers. In order

to facilitate control efforts, the authorities hope that any dead martens, foxes, or other prey animals that are found will continue to be sent to the State Institute of Veterinary Medicine for testing. The institute will pay for shipping costs. Local veterinarians or wilderness authorities can also serve as intermediaries.

Rabies continues to occur in that part of the Soviet Union which borders Finland. The disease is present at least in the areas around Leningrad, on the Kola Peninsula and in Estonia. According to our information, vaccine has been put out on the Kola Peninsula in the same manner as in Finland. The countries involved intend shortly to begin a cooperative effort against rabies.

According to the World Health Organization's (WHO) standards, a country is considered to be rabies-free if at least two years have elapsed since the last case, and if comprehensive testing has shown that no rabies is present in the country.

SPAIN

National Health Poll Results

90WE0143A Madrid EL INDEPENDIENTE in Spanish 17 Feb 90 p 33

[Article by Vicente Mateu and Pedro Munoz]

[Text] According to the National Health Poll prepared by the Ministry of Health and Consumer Affairs, to which this newspaper has obtained access, 44.5 percent of the Spanish people say they suffer from some chronic illness. This poll is considered one of the most valuable measurement tools for determining the population's health status. This was one of the most surprising answers, given by nearly 17 million people, whose health in the vast majority of cases will be diminished for the rest of their days.

In addition, a fourth of the people in Spain say they have just average, poor, or very poor health. In all, there are almost 10 million patients who make up the bulk of the "beneficiaries" of our health care system.

On the other side, almost 60 percent of the Spanish people say they enjoy good health. There are 6.7 million, or 18 percent, who say they have "very good" physical health. These lucky people almost never find it necessary to visit a doctor. Broken down by age groups, among the group 65 years of age and older, 60 percent say they have just average or very poor health, while in the 16- to 44-year-old age group, that percentage is under 20 percent.

Medications

In terms of the autonomous communities, Aragon, Cantabria, Navarra, and the Basque Country are those whose inhabitants say that they are in the best health, with percentages exceeding 70 percent of the population over the age of 16. However, the Canaries, Extremadura and Galicia are the leading communities in terms of the population percentage dissatisfied with their health.

The ministry of health also asked the persons interviewed about their vision problems, which affect 15.3 million Spanish citizens, especially women; about their hearing problems, affecting 4 million; or if they had spent one day in bed because of illness during the 15 days immediately preceding the poll—1.5 million.

Another statistic of interest in determining the health status of the population is their use of medications. Taking the same 15-day period used in the preceding paragraph as a reference measure, 11.6 million Spanish citizens, mostly women, say they had taken some medication during that period.

Logically, the direct outcome of a poor health condition is visiting a doctor. More than 11 million Spanish citizens visited a doctor within the three months preceding the poll, 4.5 million during the past year, and almost 4 million had spent more than two years without seeing a doctor.

Of those who visited a doctor, 80 percent were covered by Social Security, but 14 percent used their medical group or a private physician. Broken down on the basis of medical specialties, it is general medicine, the "primary care physician," that absorbs the largest part of the health demand in Spain. So it is walk-in clinics, therefore, along with health centers, which receive the highest percentage of visits, slightly above 70 percent of the total. The sole purpose of more than a tenth of these visits is to obtain prescriptions.

On the subject of hospitals, well over 2 million persons had hospital stays during the year preceding the poll. Of these people, 380,000 were retired and 642,000 were housewives. Over 400,000 children under the age of 15 were hospitalized.

Catalonia is in the lead in the number of persons hospitalized, with 342,000 people over the age of 16, ranking even ahead of Andalusia and Madrid. The smallest number of people hospitalized was in La Rioja, where only 14,000 citizens needed specialized treatment. Among the reasons given for entering a hospital, somewhat more than a third listed surgery, and almost 18 percent were to give birth. However, births are declining dramatically every year, so the latter figure must be considered as showing a downward trend.

Population Distribution Based on Evaluation of Health Status, Sex and Age; Population Group 16 and Older

Absolute Numbers (in thousands)

—	Total	Evaluation of Health Status					
		Very good	Good	Average	Poor	Very poor	Don't know; did not answer
Total	27,756	3,983	14,770	6,595	1,852	395	161
Sex and Age							
Total	27,756	3,983	14,770	6,595	1,852	395	161
16-44	15,499	3,041	9,576	2,328	386	80	88
45-64	8,067	728	3,772	2,575	777	171	44
+ 65	4,177	214	1,413	1,690	688	144	29
No answer	13	—	9	1	1	—	—
Men	13,311	2,204	7,491	2,657	735	149	74
16-44	7,760	1,678	4,843	989	167	42	40
45-64	3,773	433	1,942	997	317	58	26
+ 65	1,774	93	703	670	250	48	8
No answer	5	—	3	1	—	—	—
Women	14,445	1,778	7,279	3,937	1,117	246	87
16-44	7,739	1,363	4,732	1,339	219	38	48
45-64	4,294	295	1,830	1,578	460	112	18
+ 65	2,403	121	709	1,020	437	96	21
No answer	5	—	3	1	—	—	—

Waiting Half an Hour

According to the National Health Poll, 4.6 million people visit emergency services annually in search of health care. The vast majority consists of a population group with either a primary level of education or, most of all, with no education, between the ages of 17 to 44.

Catalonia and Madrid, along with Andalusia, are the autonomous communities with the highest incidence of emergency services use, and where, precisely, the operation and organization of these services have been most criticized. A hospital like Madrid's Gregorio Maranon Hospital, in which emergency visits are the main source of problems and scandals, handles an average of 400 emergency cases a day.

In the section on the use the citizens make of health services, the National Health Poll also included questions on the average amount of time spent in reaching a health care facility and the average waiting time. Overall, an estimated 15 to 17 minutes are spent reaching the place where the consultation takes place, and almost half an hour—longer if it is a walk-in clinic—is spent waiting to be treated. In emergency services, the average waiting time for care is approximately 17 minutes. Trips that take a longer time are those whose destination point is a hospital outpatient clinic.

Going to the Dentist

The oral and dental health of the people of Spain is also covered in the National Health Poll. This is a service with very limited Social Security coverage, and attempts are being made to include something more than the simple function of "pulling teeth" in this coverage. In fact, since the preparation of the National Health Poll a little more than year ago, room has been made in public health for practically complete oral and dental care up to the age of 14. Some autonomous communities, like Cantabria, have initiated preventive programs in this field at their own expense and risk.

The poll reflects the time elapsed since the last visit to the dentist before the poll was conducted. Among the population group older than 17, almost half of the answers listed in this section were "don't know or no answer," and 13 percent say they never go to a dentist. The situation is similar among the younger population group between the ages of one and 15, in which of a test population of over 10 million people, 6 [million] have never been to a dentist. Most of those who do go to the dentist begin their dental visits at the age of five, and just as with adults, they go in order to have their teeth cleaned or to obtain some dental appliance. The always necessary routine visits and checkups account for a very low percentage of visits made to dentists.

A Serious Confession

For a large proportion, if not the majority of Spanish society, health is one of the most desirable values, just as unemployment is one of the deepest concerns. Recent polls made by different groups have already shown this. So far there are no surprises. The surprises start when we

see the National Health Poll, which was ordered by the government, which tells us, in a highly revealing confession by the Spanish people, that health in this country is as deficient as the state of our health care facilities is chaotic.

Reading the poll provides us with the best argument to corroborate our impressions and our repeated reports on the deplorable state of Public Health. If a fourth of the Spanish population feels that their health is just average or poor, and if 44.5 percent of the persons interviewed, approximately 17 million people in Spain, say they suffer from some chronic illness, no further reasons are needed to ask the government to take urgent steps, for things should not be allowed to continue in this state for much longer.

The socioeconomic abyss which, in Spain as elsewhere, divides the economically sound regions from the forgotten regions, is shown in this poll with detestable eloquence. By now the minister of health, Mr. Garcia Vargas, knows that the people in Extremadura, in the Canaries and in Galicia feel they suffer from the worst health. That should not be a reason for them to feel left on the sidelines as well.

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